

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEC 13 1937

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

39666  
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. **791**  
(b) Township ..... Primary Registration District No. **1003**  
(c) City **St. Louis** (d) Street No. **Park Lane Hospital** St. **10653**  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Anna C. Holzschuh**

(a) Residence, No. .... St. **NR** **Owensville, Mo.**  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED  
HUSBAND OF  
(OR) WIFE OF **Casper Holzschuh**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Dec 1, 1893**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
**35** 43 11 14

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) **October 1937** 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) **Owensville, Mo.**  
(STATE OR COUNTRY)

13. NAME **Fred Pletz**

14. BIRTHPLACE (CITY OR TOWN) **Gasconade County**  
(STATE OR COUNTRY) **Mo.**

15. MAIDEN NAME **----- Creamer**

16. BIRTHPLACE (CITY OR TOWN) **Gasconade County,**  
(STATE OR COUNTRY) **Mo**

17. INFORMANT **Casper Holzschuh**  
(ADDRESS) **Owensville, Mo.**

18. BURIAL, CREMATION, OR REMOVAL

PLACE **Owensville, Mo.** DATE **11-13 1937**

19. FUNERAL DIRECTOR **Albert H. Hoppe Inc.**  
(ADDRESS) **429 N. Euclid Ave.**

20. FILED **NOV 17 1937** **J. H. Bredeck**  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **11-16** 19 **37**

22. I HEREBY CERTIFY, That I attended deceased from **Oct 13 -** 19 **37** to **Nov 16** 19 **37**

I last saw her alive on **Nov 16** 19 **37** Death is said

to have occurred on the date stated above, at **11:50 A.M.**

The principal cause of death and related causes of importance were as follows:

**Chronic Myocardial Degeneration** Date of onset

Other contributory causes of importance:  
**Toxic Adenoma of Thyroid G.**

Name of operation **Thyroidectomy** Date of **10/27/37**

What test confirmed diagnosis? **-** Was there an autopsy? **-**

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? .....  
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) **J. William Porth** M. D.  
(Address) **4930 Lindell Blvd**

STATEMENT BY LICENSED EMBALMER

I, Guy W. Wilkinson, Licensed Embalmer No. 3575  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by me  
..... L. E. ....  
No ..... or by ..... Registered Apprentice No. ....  
working under my personal supervision.

Signed Guy W. Wilkinson  
Licensed Embalmer No. 3575

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)